STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155741	A. BUILDING _____ B. WING _____	R-C 11/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTHCARE	2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for the Post Survey Revisit to the Post Survey Revisit completed on October 07, 2011, to the Investigation of Complaint IN00094742 completed on August 19, 2011. This visit was in conjunction with the Post Survey Revisit to the Post Survey Revisit completed October 07, 2011; to the Post Survey Revisit completed on August 19, 2011, to the Investigation of Complaint IN00092695 completed on July 07, 2011. This visit was in conjunction with the Post Survey Revisit to the Investigation of Complaints IN00097319 and IN00097468 completed on October 07, 2011. Complaint IN00094742 - Corrected Survey dates: November 28 and 29, 2011 Facility number: 004700 Provider number: 155741 AIM number: 100266630 Survey team: Kimberly Perigo, RN Census Bed Type: SNF/NF: 48 Total: 48 Census Payor Type: Medicare: 01 Medicaid: 44 Other: 03	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155741	A. BUILDING _____ B. WING _____	R-C 11/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTHCARE	**2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	Continued From page 1 Total: 48 Sample: 07 Friendship Healthcare was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to Complaint IN00094742. Quality review 12/01/11 by Suzanne Williams, RN	{F 000}		